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FRIDAY, DECEMBER 7, 2018

11:00 A.M. CT

HOW TO TEACH SUICIDE PREVENTION CLINICAL PRACTICE GUIDELINES TO HEALTHCARE PROFESSIONAL TRAINEES

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>> ANDREW BUDSON: Hi, everyone. It's our pleasure to welcome you to our VA Boston First Friday Faculty Development Presentation Series. I am Dr. Andrew Budson, here with Dr. David Topor, as always, and we are very pleased to introduce -- we are hearing a little bit of sound. Oh, it may be from the Pictel. Those on the Pictel, please make sure you mute your lines. Thank you very much for muting your lines. Sorry about that.

So it's my pleasure to introduce Dr. John Bradley. Dr.

Bradley is chief of psychiatry as well as acting director of mental health here at our VA Boston Healthcare System. He is also an associate professor of psychiatry at Harvard Medical School and an adjunct clinical professor of psychiatry at the Uniformed Services University. And we are all very excited to hear from Dr. Bradley how to teach suicide prevention. Dr. Bradley.

>> JOHN BRADLEY: Andrew, thank you so much for the invitation to present to the group this afternoon.

What I hope to do today is kind of a blend of two things -- share with you all how I teach the subject to our trainees and clinicians, and also impart some knowledge about the current state of suicide and suicide prevention in the VA.

Much of the presentation has its roots in the 2013 VA/DOD suicide prevention clinical practice guideline, of which I was one of the coauthors, so that informs much of the knowledge base learning and over the years we've been presenting this material in a number of different academic forums, to include workshops at the American

Psychiatric Association, various other academic meetings, and have included it as part of the curriculum for our psychiatry residents. So hope to share that journey with you all today.

I have a brief abstract here which I've just covered, so we won't go into that. Those, I imagine people can download the slides on Adobe Connect and feel free to use these slides as part of your teaching activities.

What we hope to do is summarize the challenges associated with teaching such a high-risk topic, such as suicide prevention, a topic about which everyone is anxious, and most practitioners don't feel like they have the requisite skill set to do so competently. So we hope to translate the available evidence, understand what clinicians are experiencing in their clinical activities, really address some of the psychological dynamics associated with suicide risk assessment that really handicaps the clinician and provide ideas on how we can disentangle that handicap from the risk assessment and apply these lessons to our clinical practice.

I don't have any conflicts of interest to report.

And again, much of what will be covered today has its roots in the 2013 suicide prevention clinical practice guideline, which is available at the link below, healthquality.va.gov.

So I'd like to start by providing a framework for what we do, and you know, address the teaching principles that I follow when teaching this very difficult subject and understanding that, really, context is everything. And what I mean by that is that the clinical encounter around suicide risk assessment is both a high-stakes clinical encounter, and it usually happens with some important dynamics going on between the clinician and the patient that we'll get into in a few moments.

I'd also like to teach the epidemiological foundation, you know, about the rates and risk factors for suicide so that people have that as part of their knowledge base.

And I like to use case-based learning. I usually start the presentation when sitting in a classroom asking for a show of hands, which we are not able to do here in this

forum, but a show of hands for how many people in the room have known someone who has attempted or completed suicide. And then we pause and look around the room, and it's almost universal, you know, in large groups of 20 or more, there's usually only one or two people who don't raise their hand, and that's an important starting point in teaching the subject because, you know, suicide epidemiologically is fairly rare, but when it occurs, it affects many more people than the patient him or herself.

I mentioned before and will mention again the power dynamic associated with the suicide risk assessment. And that you know, recognizing that the patient is really feeling at the low end of that power dynamic, the clinician at the higher end with the ability to hospitalize and commit a patient, but the patient ultimately has all of the power in terms of whether or not they attempt suicide at their time and place.

And in that this is such a high-stakes experience for both the clinician and the patient to really pay attention to

the affect of the situation because that will inform your assessment and really lead the treatment effort to really address the affect that's in the room as a result of both the experience of the patient and the uncertainty in predicting suicide.

We want to integrate all of these guiding principles into the assessment and always remain curious. When teaching this, I am always seeking to engage the learners in their speculation, identifying their biases, and exploring together the content of the knowledge so that we get a better understanding together of what's going on and identify where are the areas where we need to focus more, maybe.

Okay. Is this better for people?

So with regard to context, we want to establish what the relevance of the topic is for the learner. And this is one of the reasons why I ask how many people have known somebody who has attempted or died by suicide. I also, for a clinical audience, ask how many people have lost a

patient to suicide, and this is a really important question for us all because of the shame associated with suicide and the shame associated with being the clinician who loses a patient. We really need to change that dialogue because suicide is the occupational hazard within psychiatric practice, just as heart attacks are for the cardiologist.

So we want to establish whether suicide is common or rare, and suicidal attempts, suicidal thinking, as well as completed suicide, and teach that up to 10% of the population have experienced serious suicidal ideation at some point in their lives, and so that's a pretty significant number of people that are potentially affected and people for whom we might be responsible for caring for.

We also want to address the relevance of whether we are talking about a high or a low risk probability. It's one thing to teach about common illnesses that aren't fatal, but it's another thing to teach about something that is so difficult to predict and such a high risk in the clinical setting because that really amps up the affect that's associated with the teaching.

We also want to appreciate whether the subject is straightforward in, say, the treatment of pneumonia, versus more nuanced and multifactorial, like suicide risk assessment.

Acknowledging how difficult the topic is to discuss is really important because there are just so many different biases associated with suicide and learning about this, that you know, it's remarkable that so few medical students and -- medical schools and training programs really delve into suicide risk assessment in any significant way. So there is a stigma that's associated with suicide that has to be addressed. And people's learning about this is affected by their personal experience. Whether they have themselves experienced suicidal ideation or had a family member or a friend die by suicide is important to understand because that can be -- that can create certain barriers to learning.

As with any teaching, one of the challenges is dealing with the cognitive biases that are associated with the subject and just interpersonally talking about such a high-

stakes subject, students often have a fear of revealing their ignorance about the subject and fears of revealing their cognitive biases that need to be addressed.

So I start by teaching some of the relevant epidemiology, and this shied from the CDC tells an important story about how the suicide rates in the United States are rising, and that this rise in suicide is one of the factors that is leading to the nation's third year in a row of decreasing life span. So it's important to recognize that this is a significant public health concern, one that we should really develop expertise to deal with. And we see in this graph that the suicide rates are rising for men and for women, and so this is a fairly equal opportunity killer, and -- but there are differential rates in terms of completed suicide.

I share some more epidemiology that the suicide rates are rising in almost all age groups for both men and women, apart from the age 75 and older, which have experienced a decrease in their suicide rate since 1999.

So it's really important that we get a handle on this and recognize that in some age demographics, it's the second leading cause of death.

Here are some VA from our VA suicide data report from 2008. It shows the variable rise in rates of suicide for various Veteran demographics. And I point out that the graph that seems to deviate from the rest of the curve are those Veterans aged 18 to 35. This is really an important opportunity to engage the student in speculating why that may be. For example, I taught a course yesterday with some interns at one of our affiliates, and it generated quite a lot of discussion speculating why this younger cohort is having a greater increased risk of suicide than others to include the influence of social media, disconnectedness from communities, and a whole host of other things, to include substance use disorders. And this is really an opportunity to engage people to think about the root causes of suicide.

Interestingly, you know, one of the questions is is the Veteran population significantly different from the non-

Veteran population? And curiously, among 18- to 35-year-old non-Veterans, their rate of increase of suicide is exactly the same as the Veterans. So both have increased by 22% over this time period since 2005.

We want to appreciate the variable risk that the men and women are dealing with in our population and in our Veteran population in particular. We know that Veterans are at increased risk over non-Veterans for dying by suicide. This standardized mortality ratio tells us that men are at 1.5 times the risk of their non-Veteran controls, and women are at twice the risk of their non-Veteran controls. So this is really an opportunity for us to do something different and pay special attention to our Veteran population as a population at increased risk for suicide and really begs us to think about what we might be doing differently to turn this curve around.

We also like to teach about the methods associated with suicide, and this graph really tells us the story of how firearms are really an important risk factor for death by suicide. And when we look at firearms deaths, half of the

suicides that occur for non-Veterans are related to firearms. But in the Veteran population, almost 70% of those deaths are related to firearm use. Both for men and, increasingly, for women. So that begs us to think about how we assess the risk of firearms as part of our normal healthcare screening activities and, in particular, address the risk of firearms for our patients with mental illnesses, substance use disorders, and suicidal ideation.

One of the concerns that I would say biases that people raise is that there's nothing you can do about suicide, that once people get it in their mind there's nothing you can do to convince them otherwise, and that to take it to its extreme, that treatment is not effective.

I use this slide to tell a story about, in contrast to all of the other slides that we've shown so far about rates of increased -- rates having increased across all sorts of demographics, these are data from the VA that show patients getting treatment for their mental illnesses and substance use disorders and how these trend lines are decreasing since 2001. So this really tells the story that

effective treatment can bend the curve, and I really want to reemphasize that as we move forward in the teaching about what are some of the effective treatments that might be employed.

There's a general sense of pourlsness with regard to managing patients at risk for suicide, and this is meant to say that we actually can do something that helps our patients, and we ought to really think about how we assess them and how we treat them to help them recover.

In terms of clinical relevance, I share data, this is from VA because I am mostly teaching in the context of VAs, but the civilian data are exactly the same, that 80% of people who attempted suicide have seen a healthcare practitioner within the past month. So this is my launching pad as a teaching point that this represents a tremendous opportunity for us to be engaged around the question, to do effective screening, and to keep our ears and eyes open for potential risk of suicide so that we don't miss the opportunity of this most recent clinical encounter.

These clinical encounters occur both within primary care

and within clinical areas. It is important that we see this as a healthcare concern and we engage, as we have in the VA, to provide screening for suicide risk and further develop structures in place to evaluate and manage patients at risk for suicide.

So with that background, I then start a discussion around why people kill themselves, and I mentioned some of the teaching that we did recently looking at the increased rate. But it's also important to understand the general context.

Suicide, like substance use disorders, can be considered diseases of despair. And we want to engage the learners in identifying what some of the root causes of suicide might be, what some of the psychological experiences that people are having that lead them to suicide, to really begin to set the stage for learning about the risk factors and predictive factors associated with suicidal behavior.

This form isn't necessarily conducive to having that discussion, but I would encourage engaging your learners in identifying both the speculative and theoretical

underpinnings for suicidal behavior.

I then shift gears and acknowledge this question of the struggle that we are in with our patients when assessing their risk for suicide, and that struggle is really around the dynamic of fostering autonomy versus taking a posture of paternalism with regard to the clinical encounter. You know, in a whole health perspective, we want to maximize the patient's autonomy and decision-making and involvement in their healthcare.

The suicide risk assessment is often the most difficult time to do that. When a patient is presenting in cry cities, they are the least likely to be engaged in a truthful way with their healthcare system. Usually they are brought in by someone else who might be concerned about them, and they are struggling to maintain their dignity, their autonomy, their sense of control. We, on the other hand, are struggling with our own sense of vulnerability, the risks that we are dealing with, our limitations of clinical intuition, and indicators of suicidal risk. So we are at this power differential where the patient is struggling to stay

free and we are struggling to, frankly, cover our butts. So how do we change that dynamic in a way that allows us to be therapeutic, to be empathic, and in a way to really listen to the patient and evaluate their risk. It's really a difficult situation for us to be in, and one of the principles that I teach is that on the initial encounter, the least reliable data are the words that the patient tells us to reassure us and our own limitations of clinical intuition. We all believe as clinicians that we are skilled, that we develop positive relationships with patients, that we want to believe our patients, and that we can trust our intuition in that encounter. But the dynamic setup in these evaluations makes all of those assumptions untrue. And so we have to rely on other information to make this life-or-death risk assessment decision.

So some of the patient factors that we need to take into consideration is the likelihood that the patient is not being as truthful with what is the depth of what is going on for them as in other healthcare settings. They, again, are feeling ashamed, they are feeling out of control, they

recognize the power differential that if they say the wrong thing their autonomy may be taken away by virtue of being hospitalized involuntarily. And they are feeling hopeless. They got into a situation where they are feeling acutely suicidal, and they don't know if there's anything that can be done to help.

They are also dealing with psychosocial context of what's going on in their life that may have been driving the train of suicidality. And they have a skills deficit in terms of solving the problems that lead to suicide and supporting themselves. And so the patient is really feeling powerless, vulnerable, fearful, and in many ways wanting to protect themselves.

On the mirror image, the clinician, because of the patient's shame and presentation, particularly if there has been a nonlethal suicide attempt, particularly if it is at 2:00 in the morning and various other settings can be at risk for having a lack of empathy with these patients. So that creates a barrier to learning about the situation that they are experiencing and providing a therapeutic roadmap

out of the crisis.

Clinicians also fear making mistakes, particularly in the context of a healthcare system or even in a private practice, that making a mistake around suicide risk assessment can both result in the patient's death and litigation. So there's a great impulse to cover your butt and hospitalize the patient as the only reasonable alternative to a high risk for suicide. And so what we want to teach is that there are actually different clinical pathways than hospitalization to help empower the clinician to be able to manage the situation.

The hopelessness that the patient feels is often projected onto the clinician when they describe the depth of their despair and the circumstances around their suicidality. And so the clinician may respond to that by feeling hopeless themselves and not knowing what to do.

Institutional culture plays a huge role in this. At many institutions, you know, there might be a culture of fear or a dullture of blame, that the clinician responds to and may limit their therapeutic thinking around what to do for the

patient. And let's not forget the baseline knowledge deficits that we are hoping to address through the promulgation of this clinical practice guideline.

So I use that, then, as the launching point to talk about suicide risk assessment per se, and then to jump into the treatment of high-risk situation so that people have a foundation and tools available when they take care of their next patient.

I'll just back up just a second. As part of the CPG, we reviewed almost 17,000 articles having to do with the assessment of suicide risk, pared that down into those articles that demonstrated a significant predictive value associated with suicide risk assessments, and developed recommendations out of that work.

The framework that we describe has to do with identifying the warning signs associated with suicide, those things that the patient expresses or behaviors that they exemplify that can be picked up by another person. So they are either expressions of despondency or preparations for suicide that we all ought to keep our eyes and ears

open for.

Those of us who have studied suicide risk have seen these laundry lists and laundry lists of risk factors associated with suicide. I will tell you that these risk factor lists are not very helpful in that most of them have zero predictive value associated with them, and many of them are nonmodifiable risk factors that are particularly unhelpful in that they don't serve as an opportunity for therapeutic intervention. So what we tried to do in the clinical practice guideline is define those risk factors that are more predictive than others or serve as precipitants to suicide and describe those as other risk factors that are related to but not predictive of suicide, chronic risk factors, and we also want to appreciate that there are protective factors that even people who are chronically and desperately suicidal may rely upon to prevent themselves from acting on their suicidal impulse.

We tried to think about these risk factors thinking about biosocial factors in medicine, and also thinking about the risk factors of suicidal, and since this is a joint

VA/Department of Defense clinical practice guideline, looking a the some of the military-specific risk factors for suicide.

I know most people can't read this chart on their screens, but I will point out just a few of the positive predictors of suicide.

In the behavioral recommend, these preparatory behaviors that people engage with or rehearsal behaviors are really porpoise indicators as you are doing your lifetime and recent suicide history-taking. For example, the first patient that I lost to suicide was while I was a resident in San Francisco, who jumped from the Golden Gate Bridge. He happened to survive and was brought to our hospital, which was right at the base of the bridge. He described that in the month prior to his suicide attempt that he walked out on the bridge every single day to feel the wind whip past him, to hear the cars driving by, to look down at the water and imagine again and again what it would be like to throw his leg over. So these rehearsal behaviors are really important to pick up on in our clinical

encounters.

Another patient that I took care of shot himself with his firearm, and he survived, but in the weeks prior to his suicide attempt, he would load and unload his firearm. He would dry cock it. He would hold it in his lap and look at it. So we want to understand, you know, how far along the suicidal rehearsal has gone.

In the biological risk factors, we want to look for things like agitation, insomnia, unremitting pain, and a number of other factors. I won't go through the laundry list, but we really want to appreciate these things when we are doing our suicide history.

Psychologically, the important components are really around impulsivity, self-loathing, and perceived burdensomeness. The sense of hopelessness that people experience is really important to understand and how people have gone down this one-way path towards suicide.

The social risk factors that are predictive of suicide really have to do with loss -- loss of love, loss of esteem, loss of status -- and thinking about shame that really make

facing the world unbearable. And so these are very important predictive factors if somebody is experiencing suicidal ideation and experiencing a great deal of shame that that's a patient that we really should be worried about.

Military-specific risk factors include things having to do with shame and loss of status and disconnectedness from support systems.

The protective factors that we identified in the literature are less robust, but really organized around three different buckets: Having a strong sense of psychosocial support and a network that a person can rely upon; having inherent positive personal traits, like help seeking and impulse control, problem-solving skills, et cetera, et cetera; and having access to healthcare, which is something that our Veterans are fortunate to enjoy.

So how to make sense of all of this, all of these different factors and the risk for suicide. You know, one of the biases that people believe, a myth, if you will, is that people who are suicidal are always suicidal. And are

eventually at risk to die. And nothing really could be further from the truth. So what we like to teach is a recovery-oriented model for suicide that, just like any other chronic illness, the individual's vulnerability changes from day to day and minute to minute based on the risk factors and precipitating factors that push them towards suicide and the protective factors that pull them back from suicide and the things that society and clinicians can do in terms of means restriction to prevent a lethal suicide attempt. As clinicians, we live in the orange boxes, where we are charged with assessment, intervention, and treatment, that if effective, pushes the patient back toward recovery and wellness; and if too late or not quite effective enough may result in a suicide attempt to completion. In either case, of recovery or attempt, we have a continued role to play. In recovery, our role is monitoring and relapse prevention, and in the case of an attempt or completion, our role is in post-response. Both for patients and family members, and critically, for our team members and ourselves. Mentioned before the shame associated

with losing a patient to suicide. It is remarkable how much stigma clinicians bare when losing a patient to suicide. It becomes a deep, dark secret.
The person feels vilified and blamed by their peers and their organization whether or not that is true. The usual and customary organizational responses of peer review, root cause analyses, et cetera, serve to excoriate the wounds that the clinician is experiencing. So we really have to think about how, as an organization, that we respond in the wake of a suicide to support the clinician and help them regain their sense of esteem within the organization. And that's a challenge for us all because inherent in the loss of a patient to suicide is a feeling of guilt and recrimination that we, as clinicians, are well trained to perform upon ourselves.

So with all of this in mind, we want to be able to stratify patients' risk. Why do we do that is that well, of course, because each level of risk imparts the patient on a different clinical pathway. So we want to think about first, what are the indicators of high risk, and high risk

meaning more likely than not to attempt suicide in the short-term; intermediate risk, likely at some point to attempt suicide in the future; and low risk, meaning no more likely than anyone else to attempt suicide.

And when we review the literature, this risk stratification really focused around four different features. One was the nature and intensity of the suicidal ideation. The patient's intention to act on that suicidal ideation. Their ability to maintain impulse control. And protect themselves from acting. And the behaviors associated we talked about before, if those are present, then the person is demonstrating that they are at high risk for another attempt.

And there are a number of different motels that are out there for assessing suicide. The VA is adopting one that I will talk about in a little bit of detail, but that's kind of the first step, you know, the entry into this clinical practice guideline, if you will, having the warning signs and then being risk stratified. But that's not the be all and end all. There is much more of an assessment that needs to

happen to really determine at what level of risk and, therefore, what level of intervention the patient needs. And that includes analysis of the contributing factors like risk and protective factors, and then the supports and treatments that are available within the healthcare system to offer the patient.

I mentioned the Columbia suicide severity screener, which is in the new suicide risk assessment that the VA is rolling out, the primary screen done in primary care, emergency departments, and certain high-risk clinics, like sleep and pain clinics, is the two depression screening questions and one suicide question. Pardon me. If that's positive, then the secondary screener is the Columbia suicide severity screener, which is useful in that it provides the clinician with a framework for asking the questions. And stratifies the person's risk according to the intensity of the suicidal ideation and how far the planning has gotten along.

So the first question has to do really with what we call passive suicidal ideation: Have you ever had thoughts

that you would be better off dead?

Second question is active suicidal ideation: Have you actually had thoughts of killing yourself?

The third, question three, is asking about their plans and if they've developed any plans. Do they have intent? And have they really developed the methods they would use into a plan with all of the contingencies?

And then we ask a lifetime question that can help stratify risk as well. And the nice thing about this tool is it help us really gauge the intention of the suicidal ideation and begin to start treatment planning.

So I mentioned in the preliminary comments that we really like to do case-based presentations, and here's an opportunity to kind of test drive this Columbia scale model and really ask the learners to demonstrate their thought process around assessing risk. And I have a series of vignettes that we go through that are on the basis of the presentation at various levels of risk, and then ask some provocative questions to really challenge the assumptions that are being made. You know, for example, this case

has to do with a 68-year-old married white man, recently retired, past psychiatric history of bipolar disorder and alcohol use disorder, brought to the ED by his wife, intoxicated, expressing a wish to be dead, which is item number 1 on the Columbia scale. He denies a specific plan. And now when he is not clinically intoxicated, denies any intent to harm himself. He's got a history of an overdose 30 years ago.

So thinking about all of the risk factors, we have a recently retired age over 65 white male with a history of psychiatric illness and a past psychiatric history of a suicide attempt. On face value, with many of the paradigms that people have been taught, you would say that this is a high-risk individual because of his nonmodifiable risk factors and past history of suicide attempt. But when we brush that up against the latest thinking in suicide assessment instruments in terms of their predictive value, he's actually at low risk for attempting suicide. But there are some wild cards in here to be discussed, wild cards like unknown why he became

suicidal. Wild cards like his intoxication and what his future likelihood of becoming intoxicated again and reexperiencing suicidal ideation. We don't know anything about what the nature of the relationship between he and his wife are. And so this really serves as an opportunity to delve more deeply and not take it face value the demographics associated with the history.

So we jump into what are the important domains of a clinical suicide risk assessment. Thinking about when patients present with suicide ideation, and who may or may not be truthful, who may are intoxicated, that we are starting out with that we don't know if there has been an ingestion. We have to pause, and go by the numbers, doing a medical assessment, taking a good psychiatric history so we understand what psychiatric risk factors are going on, doing a complete suicide behavior history to include the current event and any past events to understand what the context of those were, and the methods that were used because that can be predictive.

We also want to do a comprehensive psychosocial

history so that we know, as we are treating this patient, what type of environment are they going into and what supports do they have. The previous case, the patient is married. Being married is a protective factor. But if that marriage is unstable, or threatened, that is a risk factor, so we really want to understand the nuances and not just take demographics at face value.

We, of course, want to explore the family psychiatric history to include a history of suicide. Has suicide been modeled for this patient? And is it seen as a comforting way out? Of course, with any evaluation, we want to do a physical examination, looking for stigmata of suicide attempts as well as evidence of a recent attempt or overdose, so a neurologic exam and relevant laboratory tests are important. And we want to do a thorough mental status exam to include questions about whether the patient seems to be engaged or resistant to the evaluation.

As always, we want to do a thorough drug inventory and medication reconciliation, because there are quite a number of different medications that actually increase the

risk for suicide attempt, and in the clinical practice guideline, we have a fairly exhaustive list as of 2013, and the list continues to evolve.

So with all of this kind of walking down the clinical path of, you know, in the case of the 68-year-old gentleman presenting to an emergency department, then walking the clinician through, well, what are the decision points that they have to negotiate? One is about whether or not the patient requires hospitalization for stabilization and treatment. And you know, we share at this point that the hospitalization, while it may be necessary for some patients to protect them in the short-term, hospitalization is a risk factor for death by suicide. Both by virtue that the most seriously ill patients get admitted, and 10% of patients who are in their lifetime who are admitted to a psychiatric unit die by suicide. So we shouldn't think of hospitalization as the cure for this crisis; that this is a long-term problem that really requires a much more coherent treatment plan.

We share the evidence that patients die after

hospitalization, and really, it forces us to beg the question why this might be, why 25% of all people who die in the year after hospitalization kill themselves within the first week. So it makes us wonder, did we actually do anything therapeutic for that patient while they were on the unit? And here's a great opportunity where I ask the students: What are the criteria for discharging a patient? And we usually get a lot of blank stares around the room, and we learn that in most healthcare systems, it's when the patient wakes up one morning and says, doc, I am not suicidal, and the entire treatment team says hooray and begins discharge planning. So without real consideration for what therapeutic interventions have been done or what has changed in the patient's life. That, of course, is changing, but still, that's all too common the scenario.

So we want to identify what are the criteria for transitioning a patient from an inpatient setting or an emergency department setting, and that there are really three factors that our working group identified. One is that the patient has no current suicidal intent. That's

really the linchpin for risk stratification. And also an enigma in many different clinical encounters. That the patient's psychiatric symptoms are able to be managed, -- the nonsuicidal symptoms are able to be managed outside the context of an inpatient unit. And that the patient has the capacity and willingness to follow a personalized safety plan.

This is really the most important piece because that tells us what the person's suicidal intent is. If the patient is able to brainstorm with the treatment team what are the things that they can do to keep themselves alive after hospitalization, that tells us that they are future oriented, motivated for treatment, and motivated for recovery. If they are bereft of the ability to do that, they are not ready for prime time and discharge at that point.

We also want to emphasize means restriction, that there are things that we, as healthcare practitioners, offer the patients that are lethal in terms of some of the medications that we prescribe. And we want to assess the risks in their home and ask the question about having

access to firearms.

We also recognize that asking this question about firearms in this context is really a high-stakes question, and there's no way to validate what the patient says. So if you ask a suicidal patient if they have a firearm, they are likely as not to say no. When up to 30% of the households here in Massachusetts have firearms in them, it's probably as likely as not that the person does, so we really need to think about how we assess the firearms ownership as we go forward.

We talked a little bit about safety planning. Here's an example of a safety plan. We have very good templates for doing this. But I'll make the point again that safety plans are not something prescribed for a patient. They are something developed by the patient with the treatment team. So their ability to actually walk through these questions and develop their own personal recovery program is really paramount here.

In the interest of time, we won't go through another case, but this, again, is another nuanced case with lots of

psychosocial implications and an opportunity to really dig in and think about what we want to know to really feel comfortable that we stratified a patient appropriately.

At the end of the teaching, we always cover, you know, what are the effective treatment interventions? Because people feel powerless about this. Does suicide resolve on its own, or do we need to do something and offer the patient something specific to help them recover? Likewise, we reviewed the literature extensively and rank ordered the recommendations that I'll cover in just a few moments.

We often in medicine think that there's a pill for everything, and so I also had the opportunity to write a chapter for Oxford textbook of emergency psychiatry to describe the principles of psychopharmacological management, that psychopharmacology may be necessary but not sufficient to reduce the risk of suicide; that we ought to treat those conditions effectively, but never believe that just treating the condition effectively reduces the risk of suicide because we've all seen examples of

patients in recovery from depression who then are finally mobilized to be able to attempt to end their life. And we share that there's no evidence or acute psychopharmacological assessment for reducing the risk of suicide, that the two medications shown to be effective, lithium for patients with bipolar disorder and clozapine for patients psychiatric disorders, those begin to emerge after years of treatment. There is emerging evidence with ketamine, of course, and we are all excited about that, but the jury is still out in terms of the therapeutic pathway for ketamine in this area.

We rank ordered the studies that we were able to review in terms of their evidence base for treating the risk of suicide. I just gave you a thumbnail sketch for that. We also did the same thing for the psychological therapy evidence, and this evidence reveals that there are really two treatments, two psychotherapies, if you will, that are shown to reduce the short-term risk of suicide, and that is cognitive therapy for suicide prevention and problem-solving therapy.

There is less but growing evidence for the use of dialectical behavior therapy for patients with borderline personality disorder, and then a number of different skills-based training and other modalities that are promising but have insufficient evidence to date.

It's critically important that we maintain follow-up and continuity of care for these patients. As we all know, won't go into too many details about that as time is running short.

And I'll mention in the realm of firearms risk assessment, offer this framework for assessing firearms in the home rather than asking a question about the possession of firearms, we assume that the Veteran has firearms and provide a health-oriented framework that lots of Veterans have firearms at home. What some people in your situation do is store their firearms away from home until they are feeling better. If you have firearms at home, have you thought of strategies like that? So this is kind of laying the foundation for we can have an open and honest discussion about firearm safety even in the midst of

a suicide crisis, and we are not about putting you on a registry or sending the police to take your firearms, but rather, collaboratively thinking about how to reduce the risk.

And with that, I'll wrap up and see if we have any questions that we might be able to delve into in the last few minutes.

>> ANDREW BUDSON: Well, thank you, Dr. Bradley, for a real wonderful talk, and we have one or two questions on the Adobe Connect system. I'll invite others to type in your questions. We only have a few minutes, so please type rapidly.

(Laughter)

One question that came up was in those two cases that you discussed where you treated suicide attempts, the survivors that had antecedent rehearsal behaviors, did they share those behaviors with anyone prior to their attempt?

>> JOHN BRADLEY: They did not in either of those cases, but some patients do. Some patients drop hints

with friends and family members. But remember that patients who are suicidal are feeling powerless and ashamed. If they had the skills to resolve their suicidal crisis, they would do so. And so they are feeling ashamed, which limits their ability to share with other people for fear of being stigmatized further. But that doesn't mean that we shouldn't be on the lookout for people who are sharing, hey, I just bought a new firearm. Oh, haven't you been depressed over the past month? Right?

>> ANDREW BUDSON: Another question on the computer is the fact that, you know, how do we tell when the patient is saying, oh, doc, I don't feel suicidal anymore. I am ready to leave? How do you know if it's really or if, as you were intimating before, they are just saying that to be released?

>> JOHN BRADLEY: So I always follow up with -- well, that's fantastic, and what has changed and what have you learned so that the person can be specific about the fact that they have integrated some new framework that has

helped them resolve their crisis, and that can often happen in the context of the safety planning that's done because the things that have worked to help them resolve this crisis are things that they can rely upon in the safety plan, which is done in the context of you are feeling better now, but you are going back out into life, and it's likely that some of these stressors will continue. So what are you going to do the next time? And that really tells us what they've integrated as part of the treatment that can convince us.

>> ANDREW BUDSON: So in the last few seconds, do you have any pearls for all the educators out there as to how to teach this content effectively?

>> JOHN BRADLEY: Well, I think it's important to acknowledge the anxiety that we all feel as clinicians and teach around addressing that anxiety, that our anxiety will drive us in our communication, in our learning, and our engagement with other people. It's important to have consultation. It's important to have peer support. That is a way that we can help manage our anxiety around

caring for these high-risk patients.

>> ANDREW BUDSON: Thank you, Dr. Bradley, very much for a wonderful presentation, and thank you all for joining us. Our next presentation is on January 4, 12:00 p.m. Eastern. We will continue this type of talk about how to teach clinical skills where we'll talk about how to teach trainees about opioid prescriptions, the opioid crisis, and about substance abuse broadly speaking.

To our partners who joined us from other federal and state agencies, we hope that you will continue to join us in the future and send us your ideas and suggestions for these talks as well. So happy holidays, Happy New Year, we'll see you in January.

(End of session, 12:01 p.m. CT.)

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